Baines D. (2004). Pharmacy economics: Are proposals for a national contract already redundant? The Pharmaceutical Journal. 273:89

Pharmacy economics: Are proposals for a national contract already redundant?

In this article, **Darrin Baines** and **Catherine Hale** examine some of the economic issues involved in designing an effective localised payment system for community pharmacists.

Community pharmacists are currently in the process of negotiating a new remuneration system and terms of service. Since 1948, community pharmacists have had “independent contractor” status within the NHS and have been paid on the basis of a national pharmacy contract. Unlike the payment system for family doctors, the existing pharmacy contract is extremely simple, with the majority of income being derived from dispensing fees. As a result, this national arrangement is easy to administer but contains few incentives to encourage pharmacists to enhance the services they offer.

Contracts

Over the past 30 years, the “contract” has become a major area of study within economics. In this article we compare and contrast emerging thinking in this field as a means of identifying issues that the designers of the new pharmacy contract should consider.

To lawyers, a contract is a binding, formal agreement between two parties that may be contested and enforced in law. However, to economists, a contract is “an agreement under which two parties make reciprocal commitments in terms of their behaviour to co-ordinate”.[1]

Under the economist's definition, “reciprocal commitments” include payments made, goods or services traded and (formal and informal) understandings of how the other party should act. Importantly, the mention of the concept of “co-ordination” implies that buyers and sellers will commonly encounter problems delivering what the other party wishes to receive. For instance, you may experience difficulties in co-ordinating your car mechanic so he does what you wish (that is, lowest cost, needed repairs only) not what you fear he wants (that is, maximum income, minimum work).

Therefore, economists examine the theoretical issues involved in co-ordinating different parties to a transaction, whereas lawyers can help enforce actual agreements made in everyday life.

Institutional framework

Despite their differences, lawyers and economists both acknowledge that contracts tend to operate within wider “institutional frameworks” that specify the society-level rules we should follow regardless of the contracts we sign. For instance, pharmacists must work within the institutional framework specified by the 1968 Medicines Act and their professional code of ethics when delivering their contracted services. As part of these arrangements, failures to act legally or ethically can be punished by the courts or by removal from the pharmacy register.

As society-level rules affect individual transactions, economists use the term “property rights” to denote “the rules which specify what individuals are allowed to do with resources and the outputs of those resources”.[2] For instance, community pharmacists currently have the right to purchase drugs for patients using NHS resources and may keep any profits made, after an agreed claw-back has been applied. However, the new contract may alter this right so pharmacists lose some of their purchasing income when a new funding formula is applied, even if this money were made legitimately.

In sum, economics suggests that pharmacists work within a specified institutional framework, with property rights that specify the resources they may access (and what profits they may make) for providing their services.

Against this background, the pharmacy contract specifies the reciprocal commitments the profession and

the Government have agreed to make when co-ordinating their economic behaviour.

Contract theory

In a book on the economics of contracts, Brousseau and Glachant identified four main questions of concern to researchers in this field:

1. Why is it difficult for economic actors to co-ordinate their activities?

2. What mechanism can be used effectively to promote co-ordination?

3. How do agents conceptualise the rules governing their activities?

4. How do contracts influence the structures governing economic activity?

In the current context, the economic actors involved, on one side, are community pharmacists and, on the other, the Government acting through primary care organisations. As questions 1 and 2 imply, the new contract should embody mechanisms (such as incentives) for co-ordinating the activities of community pharmacists that motivate them to deliver the objectives set by national and local health policy.

An initial analysis of the proposals currently in circulation suggests that the new contract will abolish the national, “fee-for-service” dispensing payment and introduce local, cash-limited budgets in its place. If such a move occurs, pharmacists will face a completely different incentive regime, which will shift the risk for overspending on service provision from the Government to themselves.

Next on the list, question 3 implies that the proposed contract will institutionalise new rules that pharmacists should follow. At present, the institutional framework governing the operation of pharmacies is separate to the arrangements for controlling primary care as a whole. For instance, pharmacists now have separate professional governance procedures managed through their own regulator, with the policing of standards being primarily outside NHS control. However, under the new contract, PCOs, Patient and Public Involvement Forums, the Healthcare Commission (formerly the Commission for Healthcare Audit and Inspection) and the National Care Standards Commission will all have powers to inspect pharmacies.

Finally, the four-part list suggests that the proposed changes to the contract will alter the economic structures governing community pharmacy. As mentioned, the economic structures for administering the ring-fenced, national “global sum” will be dismantled and pharmacy monies will be channelled through local, PCT “unified budgets”. As a result, NHS managers will be able to divert funds away from pharmacy to other areas of the health service or, vice versa, shift money from elsewhere into pharmaceutical care.

NHS plan

Economics is built upon the assumption that resources are scarce and should be used efficiently. In this context, this view implies that pharmacists should be subject to contractual arrangements that maximise the economic benefits for patients from public spending.

Under the 1946 NHS Act, pharmacists were given the explicit role of supplying all medicines and appliances that family doctors prescribe, with the result that the profession's contract focused primarily on dispensing not health outcomes.

Given the limitations of a nationally co-ordinated dispensing service, in 2000 the NHS plan announced that pharmacists should shift their attention away from their traditional role of dispensing towards the new task of meeting patient needs.

As “Pharmacy in the future” outlined, patient management should no longer be a professional issue for individual pharmacists, but should become a management objective for PCTs in which plans, targets and governance should be introduced.

With this shift, the definition of efficiency for community pharmacists changes from being “a low-cost dispensing service” to being “a fixed-cost producer of health outcomes for patients”. To demonstrate that such a move is possible, specially funded projects (such as medicines management initiatives) have been set up and are beginning to prove that pharmacists can work within new management arrangements. However, delays in the launch of the new contract suggest that civil servants and pharmacy negotiators have struggled to incorporate the evolving agenda into a remuneration system acceptable to the profession.

Vision for pharmacy

While the new contract was slowly being constructed, Labour health policy evolved and “Vision for pharmacy” was published.

According to the Department of Health, since the NHS plan was published “there have been other far-reaching changes in the NHS and it is both timely and appropriate to look again at the future shape and direction of pharmacy”.

While “Pharmacy in the future” promoted extended professional roles for pharmacists, the Vision document focused primarily on integrating community pharmacy into the NHS.

In an integrated health service, the Government believes that pharmacy services should not be uniformly based around dispensing. Instead, they should be innovative, responsive and flexible so that diverse patient needs can be met. With proposals to introduce flexibility into the mechanisms used to co-ordinate pharmacy care, the Government hopes that: “The extent to which particular services are provided will vary from one place to another ... some areas may have integrated primary care services ... in others, the local pharmacy may be the most accessible and convenient place for people to call in to discuss any health problems.”

Although diversity will be possible, the Vision document stated that pharmacies will be permitted to specialise in dispensing, if the service is run at significantly lower costs: “Some community pharmacies may choose to focus their services on the provision of highly efficient dispensing services.”

In other words, the new contract will abolish the agreed national price set by the dispensing fee and introduce local negotiations for this standardised task.

Discussion

In October 2003, the majority of respondents to a Pharmaceutical Services Negotiating Committee ballot stated that they were “happy with the outline service framework for the new contract, provided that it is supported by fair funding, an acceptable contractual environment and that a structured transition from the old to the new contract is in place”. However, these arrangements would not be tolerated if they were not funded fairly or introduced sensibly.

From the perspective of contract theory, the contract being offered to community pharmacists is not just a legal agreement that specifies the obligations of each party. Indeed, the proposed changes will require pharmacists to operate in a new institutional framework, with altered property rights, PCT-based economic structures and new incentive mechanisms.

Under the old contract, all pharmacists worked in a set of rules designed specifically for them, with one, clearly defined co-ordination mechanism: the dispensing fee. Under the new arrangements, all accredited suppliers of pharmacy services will have the same set of rights to provide NHS services using public resources.

However, the introduction of PCT-based economic structures will change the ways in which services are funded, commissioned and remunerated. For instance, nationally “ring-fencing” pharmacy remuneration

may cease when money previously spent on dispensing is included in PCT unified budgets because they are designed to include all health service resources in one pot.

Although the loss of guaranteed remuneration levels could be a worry for pharmacists, the biggest economic change ahead could be the introduction of cash-limited budgets. With local budgets replacing the national “fee-for-service” dispensing payment, community pharmacists could find themselves bearing the risk for unpredicted spending. For instance, pharmacists may be given an annual financial allocation for providing essential and enhanced services to a specified group of patients, which may not be increased if demand is greater than expected. In other words, pharmacies may have to operate like hospitals, which ration services in order to stay within given budgets.

For professionals familiar with providing demand-led dispensing services the move to priority-setting, cost control and budgetary planning may prove an interesting challenge. However, if pharmacy services were eventually to operate on the same economic basis as other parts of the NHS, the Vision document states that the need for a separate pharmacy contract may be diminished: “If, in future, NHS pharmacy costs were to switch to being fully met by PCTs, it appears sensible to consider whether the national 'terms of service' should continue in their present form or also be subject to contracts.”

In other words, there is no logical reason for the new pharmacy contract to remain when local contracting could do the same job without the added complication of referring to a national agreement when meeting local needs.

Given this fact, the Vision document announced the Government's intention to discuss with pharmacy negotiators whether the pharmacy contract should eventually be abolished in favour of more appropriate local arrangements.

Conclusions

Once community pharmacists agree to a new contract there will be no turning back. Under the new framework, the existing economic structures for remunerating pharmacists nationally will be abolished and local arrangements put into place.

Accompanying this fundamental shift will be significant changes in property rights and incentive mechanisms, which will change the ways in which pharmacists do business with the NHS. Although these new arrangements will stimulate change, the proposals for a new national contract may already be redundant, as logic suggests that PCTs do not need national rules to commission services locally.

Therefore, it must be concluded that, while the new pharmacy contract will change the ways pharmacists can do business with the NHS, it may not survive to see those changes come to the fruition that the Government plans.

References

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